

OSH RECOVERY TIMES

Volume 5, Issue 12

1

December 2009

Preserving the past

By Kylie Pine, OSHRP Volunteer



Metal Sign, Oregon State Hospital Collections

As the new hospital takes shape and the old begins to disappear, efforts to preserve the complex heritage of this Salem landmark persist. The Oregon State Hospital Replacement Project (OSHRP) continues to work on providing for the needs of the future without forgetting the past.

The renewed OSH campus in Salem will have several prominently placed historic features. The new hospital will preserve the original "Kirkbride U" portion of the historic J-Building. With a new roof, refitted foundations and abated asbestos, this historic structure will safely house administrative offices, treatment facilities and a mental health museum.

The new Oregon State Hospital Museum of Mental Health will be located under the cupola on the first floor of the preserved Kirkbride U building. The museum will tell 126 years worth of stories about the hospital and those who lived and worked here. A community board has been organized to work with OSHRP staff to create the non-profit museum.

In preparation for the new museum, the OSHRP has engaged volunteers to begin inventorying historic items on the Salem campus. To follow the inventory process, view photos of historic artifacts, read

about the history of the hospital and help identify mystery objects on the museum project's blog, go to: <http://oshmuseum.wordpress.com>.

The new hospital complex will also include a memorial for cremated remains in the hospital's custody. In 2005, the deplorable storage conditions of 3,489 cremated remains housed at OSH made international news headlines. Since then, the hospital has worked with community members to rehouse and return the remains to family members. An historic structure will be moved to the grounds on the east end of the J-Building and re-fitted as a memorial space to remember and secure the unclaimed remains.

The Oregon State Hospital is an important and often untold part of Oregon's history. Unlike the usual textbook themes of manifest destiny and the pioneer spirit, the stories of OSH provide a refreshingly human and at times discomfiting view of our past. With its future plans, OSH has done an extraordinary job of remembering the importance of this past.

Kylie Pine is a volunteer with the Oregon State Hospital Replacement Project and serves on the museum board. She can be reached at kylie.pine@state.or.us.

In this issue...

Preserving the past.....1

Keys to EHR implementation success2

New hospital names reflect theme.....4

Pre-Vettrans Day celebration "honors our own"4

Creating an organizational structure5

Recovery: Staff survey results6

Nutrition news you can use.....7

OSH new hires and retirees8

December 2009 EDD events.....8

OSH Recovery Times

is edited by Jeff Jessel. Contact him at 503-945-2892 with questions, comments or suggestions.



Keys to EHR implementation success

With the signing of a contract with Netsmart Technologies, Inc., BHIP has completed the planning phase of the project and started work on implementing the Avatar electronic health record (EHR) system. Stories of the many challenges to be faced during EHR system implementation abound, so how will we ensure that we are successful? We learn from past implementation successes and failures.

The BHIP team met with about 30 organizations, both in person and through conference calls, to research what worked and what didn't in other organizations. The lessons learned were from technology and clinical business perspectives. This information helped to shape all BHIP project plans, from the Communication, Training and Business Transition plans to the Maintenance and Support Plan that outlines how the EHR will be supported after implementation. Additionally, BHIP chose a quality control and planning vendor, Fox Systems Inc., with extensive experience guiding state facilities in the EHR purchasing and implementation process. The following are lessons learned from other organizations and how BHIP is using that information as a guide through the implementation maze.

1. Choose the system with the best fit for your organization.

One of the universal lessons learned from failed implementations was to define the functional requirements the system needs to meet prior to selecting a system. Choosing a system that needed significant customization and not having clinical staff review the clinical portions of the system also caused a number of failed implementation attempts.

Finally, other organizations advised us to look past sales demonstrations and use staff-developed scenarios to preview the system.

The BHIP team and Fox Systems met with multiple staff across disciplines and program areas at Oregon State Hospital, Blue Mountain Recovery Center and community programs to determine clinical functional requirements. When the EHR system proposals were submitted by the vendors, clinical staff evaluated the proposals against the clinical functional requirements while the technology staff evaluated the technical requirements. Additionally, staff developed the scenarios that were used during the vendors' oral presentations based on daily activities at OSH.

2. Effective change management is vital.

During research and site visits, BHIP consistently heard, "You can estimate how successful, or not, the implementation will be on how change management is addressed." EHR implementation isn't simply about technology, but about people and how they provide care. The way people do their jobs will change and the anxiety caused by that must be addressed. *Communication and staff involvement are vital.* The project needs to operate in a transparent environment where concerns and questions are welcomed and addressed. When non-technology staff members were included in configuration and testing, the chance for success increased exponentially.

(continued on page 3)

Continued from page 2

BHIP strives for a supportive environment with open, honest communication. We understand that the EHR system is only successful if works for staff and patients. To increase the chance for success, BHIP has involved and will continue to involve staff in every aspect of the project.

3. Knowledge is key to success.

In surveys of organizations that survived failed or troubled implementations, lack of staff communication and training was one of the top three reasons for failure. Communication needs to be in multiple formats, consistent and useful. Training must address both how to use the new system and how it changes each person's job. Additionally, BHIP was encouraged to promote cross-training of staff.

The BHIP team has endeavored to communicate across the hospital campuses throughout the planning process, including meetings with staff on all shifts, the BHIP Beat, e-mails and the OSH Recovery Times. This communication will continue as the EHR implementation advances.

Netsmart's Avatar solution is being used in 35 state facilities. Netsmart will work with the BHIP team in training, focusing on a train-the-trainer approach. This will build system expertise in the hospital staff and encourage communication and support among peers.

4. Strong vendor relationships are essential.

One of the major reasons for failed implementations was ineffective communication with and support from the vendor. To effectively implement, the vendor needs to understand both the technical and cultural environments. Other hospitals urged BHIP to be proactive by developing an implementation plan with deadlines and regularly monitoring

progress. Additionally, it is crucial to develop a Maintenance and Support Plan that clearly outlines who is responsible for what issues after implementation.

To address these issues, BHIP signed a deliverable-based contract with Netsmart. This ensures that payment is not made until a specific action has been completed by Netsmart and reviewed for quality by BHIP. Because Netsmart currently has 35 other state facilities as customers and has a behavioral health-specific EHR, its project team understands the essential nature of state hospitals. Additionally, during the procurement site visits and reference checks, BHIP found that Netsmart rated very high in customer satisfaction with system maintenance and support.

5. Strong executive leadership is required.

The number one reason in organizational surveys for implementation failure is the lack of highly visible, strong executive leadership. Leaders need to ensure sufficient resources, foster a positive culture and hold people accountable at all levels. The organization should embrace the opportunities that change brings.

BHIP is proud that the superintendent of OSH, Roy Orr, is a co-sponsor of the project with Madeline Olson, the deputy director of Addictions and Mental Health. Additionally, the BHIP Steering Committee has strong representation of leaders from OSH. Roy and Madeline have been very supportive of BHIP and of the staff and patient opportunities that an integrated EHR will provide.

BHIP will unlock the path to success using key lessons learned from other implementations. A successful implementation of the new Avatar EHR system will facilitate the ultimate vision of person-centered, recovery-oriented, integrated care.

New hospital names reflect theme

By Roy J. Orr, Superintendent

We have reached a point in new hospital construction where we need to make decisions about what to name the new buildings and their respective units. Our overarching theme of Journey to Recovery has been the guide for the textures, colors and furnishings selected for the new hospital. The OSH Naming Committee has submitted names that reflect this theme.

The committee's initial assignment was to name Admission, Behavior and Corrections (ABC), Psychosocial Rehabilitation Services (PRS), Transition and Neuro/Gero Services, and each of their respective units. Committee members turned to Oregon landmarks and natural resources to provide names for the following:

ABC will be called Harbors. A harbor, sometimes called a haven, provides a sheltered, protected and calm environment. The three units will be Anchorage (admission), Bay (behavior) and Cove (corrections).

PRS will be called Trails. Trails encompass the diverse and individual paths our patients will take to reach recovery. The three units will be Prospect (psychosocial), Recovery (rehabilitation) and Serenity (services).

Transition will be called Bridges. A bridge is a connection and a passage that captures a patient's move to a community or other setting to continue his or her recovery. The two transitional units will be Clearview and Horizons.

Lastly, Neuro/Gero services will be called Springs. Oregon has more than 4,000 springs. They are deep and narrow and low and wide. Some are calm and still while others bubble and percolate. To reflect the range of needs among this population, the units will be called Garden and Hope.

Representatives of patients, unions, nursing, psychiatry, social work, vocational services, clinical services, BHIP, OSH Replacement Project, communication and administration comprise the Naming Committee. If you are interested in being part of this committee, please contact Patricia Feeny on GroupWise or 503-945-9073.

Pre-Veterans Day celebration “honors our own”

By Jenny Rogers, Cultural Diversity Activities

More than 200 staff members and patients enjoyed “Honoring Our Own,” a special program at the 50 Building Gym on Nov. 10 — the day before Veterans Day.

Each veteran received a certificate of our gratitude for their military service. Lee Vogta spoke about the support he has received while at OSH and through Veterans Services. Local singer Maggie Felbur provided entertainment, and we all enjoyed two cakes beautifully decorated by FNS with American flags. If you are unaware of the artistic talent on the OSH campus, plan on attending the next Cultural Diversity Celebration. You will be glad you did.

Once again, to all who contributed to the creation of this event and helped carry it out, thank you! To all our veterans, our gratitude can not be adequately expressed. Thank you. We will see you next year.



Creating an organizational structure

By Rick Varnum, Director of Strategic Planning

Two heads are better than one.

Aristotle, 330 BC

Too many cooks spoil the broth.

Unknown

We all know it takes hundreds of people to provide quality patient care services at Oregon State Hospital. Much of our work is done with others and, as a result, the way we structure our organization is vitally important. Whether it is reporting at a shift change, informing the hospital about a broken water pipe or being a member of the Labor/Management Committee — we all have occasion to work together.

For the past year our structure has been changing and improving.

The senior leadership of the hospital has been meeting weekly since last December. Roy Orr leads this group, called the Superintendent's Cabinet. Members share information about issues from across OSH, determines organizational policy and creates plans for the future.

Since January, the cabinet has convened once a month along with the discipline chiefs as the Quality Council. The council is focused on process improvements. For example, the Quality Council charters all Rapid Process Improvements (RPIs) and Performance Improvement Teams (PITs). The Quality Council works closely with all three branches of our clinical staff: physicians, nurses and the clinical disciplines. This confluence ensures that OSH is a clinically driven hospital.

Literally hundreds of OSH staff members serve on committees, sub-committees and workgroups. The work of these groups finds its way to the Quality Council through our committee structure. Here is one example: The Seclusion and Restraint Committee meets to review our experience with restrictive events. When the members see trends in the data they review, the committee reports these to the Patient Safety Committee. Members of the Patient Safety Committee, based on the work of the

Seclusion and Restraint Committee, recommend changes they believe necessary to further reduce the use of seclusion and restraint. Quality Council approves recommendations and the change occurs.

Two important workgroups have formed this year. Both are guiding our efforts to provide centralized treatment in the new malls, with one in the 40 Building and one in the 50 Building. These workgroups show how putting two or more heads together results in progress. No one person could have accomplished what these groups have done and the successes of the 40 Building Mall are directly attributable to the hard work and perseverance of the Mall Workgroup.

It often takes time and repeated efforts to make change in a large organization. Our new committee structure is intended to be inclusive and efficient and facilitate the changes we need to make. The purpose of committees is ultimately to help make change easier. Needed changes are sometimes not readily apparent and there will be times when we won't have enough resources or staff to implement what we want to do. Through it all, we need to continue to put our heads together to find solutions without spoiling the broth. It is a delicate balance.

I hope you will review the new committee structure that has been posted on the I drive. You will find it at I:/OSH Contact Lists.

This is the time most committees are looking toward the New Year and making plans for 2010. Many are interested in new members. I hope you will consider participating and making your voice heard.

I'll close with three benefits that you and your co-workers will bring by being involved:

- Skills and knowledge from years of experience;
- Discussion, investigation and debate that otherwise could not be accomplished if we worked in isolation; and
- Collective action through decision making.

Recovery: Staff survey results

By OSH Planning, Analysis, and Research

In spring 2009, the Planning, Analysis, and Research group (PAR) administered the Recovery Self Assessment (RSA) to Oregon State Hospital staff. The RSA is a survey that measures the adoption of recovery-oriented systems and programs in mental health facilities. By administering the survey at OSH, PAR hoped to collect staff views on the scope of recovery practices currently used at the hospital.

Between April and May, nearly 500 staff members completed the RSA. The respondents included staff from both the Salem and Portland campuses and represented a wide variety of disciplines and departments. Survey participants represented all programs: Forensic Psychiatric Services, Geriatric Treatment Services, and Adult Treatment Services.

Each person who completed the survey responded to 32 statements scored on a scale of 1 to 5. A low score of 1 meant that the staff member strongly disagreed with the statement. A high score of 5 meant that the staff member strongly agreed with the statement.

The RSA focused on five key areas of interest. The first, life goals, focused on how staff members help patients pursue non-mental health-related goals. Items in this category addressed issues such as education, employment and community involvement. The second key area on the RSA was involvement. This category focused on how involved patients are in the development of hospital programming. The survey items in this group addressed patient participation in situations such as staff trainings, community services and program evaluations.

The third key area was diversity of treatment options. This category related to the variety of supports offered to patients. The survey items in this area focused on patient access to mentors, peer supports and spiritual advisors. The



fourth category in the RSA, called choice, focused on patients and their ability to make decisions about their treatment options. This area included items on changing clinicians, accessing treatment records and tracking progress toward personal goals. The final category, individually tailored services, focused on how sensitive staff members are to the individual needs of patients. The items in this category addressed the hospital's ability to provide services that reflect the cultural needs and personal interests of consumers.

The table below shows the average score for each key area based on the survey responses. Of the five areas on the survey, individually tailored services received the highest score, with an average of 3.45 (out of a possible 5.0). The life goals and choice categories received the second and third highest averages with respective scores of 3.28 and 3.24. The average score for all of the areas combined was 3.18.

Key area	Average score
Life goals	3.28
Involvement	2.65
Diversity of treatment options	3.20
Choice	3.24
Individually tailored services	3.45

(continued on page 8)

**Nutrition news
you can use**

Healthy eating at holiday parties and into the new year

By Vicki Duesterhoeft, M.S.,
Registered and Licensed Dietitian

I learned many new and exciting things at the Food and Nutrition Conference and Exposition in October, and wanted to share some of the highlights with you.

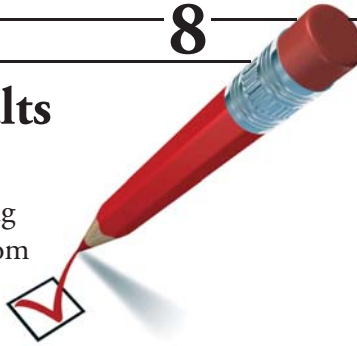
- Eating lentils or other legumes with a meal results in the “second meal effect” of decreased glycemic and insulin response at that meal and the next meal, even when the next meal is breakfast.
- High total carbohydrate intake, as well as eating whole grains, is associated with lower BMI. Increasing simple sugar intake is associated with higher adiposity.
- Patients with diabetes on low carbohydrate diets have worse HgbA1c values.
- The larger the plate, bowl or container, the more people eat. This is true even if the food does not taste good. (Everyone will eat less of a food that does not taste good, but the people with the larger plate will eat more of it than those with the smaller plate.)
- The DASH diet is very effective at lowering blood pressure. However, all those healthy servings of fruits, vegetables and whole grains won't improve blood pressure unless three servings of dairy are also included daily.
- An elevation in C-reactive protein (CRP) indicates acute inflammatory response. Obesity is a significant risk factor for increased CRP. Weight loss (for those overweight) and increased activity both decrease C-reactive protein.
- Vitamin E supplementation of older adults significantly increases T-cell mediated function. 200 IU/day provides the best response in immune function.
- Unintentional weight loss in the year prior to admission is a strong predictor of death in the next year.
- As long as CRP is elevated, prealbumin and albumin will be significantly depressed. Retinol binding protein is unaffected by the acute inflammatory response, and appears to be a more reliable indicator of nutritional status.
- Low serum albumin in the elderly is associated with an increased risk of death.
- Supplementing with fish oil increases skeletal muscle insulin sensitivity.
- Low carotenoids are implicated in sarcopenia.
- Fish oil and adequate vitamin E improve immune function; plant-based sources of omega-3 fatty acids (such as flax seed) do not provide this benefit.



Recovery: Staff survey results

Continued from page 6

Out of the 32 items on the survey, the following statements earned the highest average scores from participating staff:



- Hospital staff are diverse in terms of culture, ethnicity, lifestyle and interests (score = 4.03).
- Staff at this hospital regularly attend trainings on cultural competency (score = 3.75).
- Staff talk with program participants about what it takes to complete or exit the program (score = 3.74).

The statements that received the lowest average scores included:

- Staff actively help people find ways to give back to their community through volunteering, community services, neighborhood watch/cleanup (score = 2.44).
- Staff offer participants opportunities to discuss their sexual needs and interests when they wish (score = 2.52).
- Staff routinely assist program participants with getting jobs (score = 2.56).

The Planning, Analysis, and Research group would like to thank all staff who participated in the RSA. If you have questions about the survey or its results, please contact Aaron Dunn at adunn@dhs.state.or.us.

December 2009 EDD events

Following is a list of classes being offered at the OSH Education And Development Department (EDD) during the remainder of December. Classes are located at EDD unless otherwise noted. For more information about these classes, call 503-945-2875.

Boundary issues: Dec. 8

8 a.m. to noon.

Assertive boundaries communication: Dec. 10

8 a.m. to noon.

Patient abuse prevention: Dec. 14

1 p.m. to 5 p.m.

General orientation: Dec. 1-7, 14-21

all 8 a.m. to 5 p.m.

Ed day: Dec. 8 and 22

8 a.m. to 5 p.m.

Pro-act refresher:

Dec. 1-2 (1, 8 a.m. to 5 p.m.)(2, 8 a.m. to noon)

Dec. 3-4 (3, 8 a.m. to 5 p.m.)(4, 8 a.m. to noon)

Dec. 15-16 (15, 8 a.m. to 5 p.m.)(16, 8 a.m. to noon)

Dec. 17-18 (17, 8 a.m. to 5 p.m.)(18, 8 a.m. to noon)

Dec. 29-30 (29, 8 a.m. to 5 p.m.)(30, 8 a.m. to noon)

RN leadership training: Dec. 29

(Required for all new RNs/LPNs)

8 a.m. to 5 p.m.

OSH drivers' training:

Dec. 9 (1 p.m. to 3 p.m.)

Dec. 17 (10 a.m. to noon)

Emergency equipment training: Dec. 14

1 p.m. to 5 p.m.

Contraband training: Dec. 10

1 p.m. to 5 p.m.

Active listening communication: Dec. 8

1 p.m. to 5 p.m.

Humor as a therapeutic tool: Dec. 16

1 p.m. to 5 p.m.

Leading change (OSH managers only): Dec. 11

8:30 a.m. to 4:30 p.m.

Asbestos training: Dec. 9 and 21

8 a.m. to 10 p.m.

Bipolar disorder - Pharmacology of drug treatment:

Dec. 3 (11 a.m. to noon)

Dec. 4 (2 p.m. to 3 p.m.)

Pharmacology of substance abuse: Dec. 9 and 10

all 1 p.m. to 5 p.m.

CMA pharmacology: Dec. 2

1 p.m. to 5 p.m.

DSM IV axis II: Dec. 1

8 a.m. to 5 p.m.

OSH new hires and retirees for December

Welcome to OSH

Adrian Alaniz	Transporting Mental Health Aide	Amy D Navia	Mental Health Registered Nurse
Emily Bowyer	Mental Health Therapy Technician	Michael K Nix	Pharmacist
Lisa L Branting	Mental Health Registered Nurse	Anthony C Pabst	Mental Health Registered Nurse
Kenneth M Bricker	Operations and Policy Analyst 2	Kristene K Rodriguez	Mental Health Registered Nurse
Matthew W Clark	Mental Health Registered Nurse	Laurier Rokusek	Mental Health Therapy Technician
Barbara A Cuevas	Mental Health Registered Nurse	Shirley M Schoenborn	Mental Health Therapy Technician
Daniela G Ganeva	Mental Health Registered Nurse	Larry R Shirley	Mental Health Therapist 1
Lori L Graber	Mental Health Registered Nurse	Diane Stocking	Food Service Worker 2
Christopher M Hatch	Mental Health Registered Nurse	Kristiina E Thomas	Mental Health Registered Nurse
Emily R Henness	Food Service Worker 2	Eric M Tillet	Food Service Worker 2
Joanne M Jay	Food Service Worker 2	Marina SS Will	Custodian
Steve Jones	Transporting Mental Health Aide	Pamela A Wynia	Mental Health Therapist 2
Samantha A McCarty	Food Service Worker 2		
Arlene J McKenna	Mental Health Registered Nurse		

Promotions and reassignments

Gideon P Alifua	Transporting Mental Health Aide	Eddie J Ramirez	Office Specialist 2
Sean Michel Branch	Transporting Mental Health Aide	Shawnee L Topping	Transporting Mental Health Aide
Rebecca L Curtis	Principal Executive/Manager E		
Diane J Frederick	Mental Health Registered Nurse		
Nicholl Helms	Transporting Mental Health Aide		
Yevgeniy Lyakhovetsky	Mental Health Security Technician		